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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

October 19, 2021

Robin Vaughn, Executive Director
Email: rvaughn@brandycare.com
Brandywine Living At Litchfield
19 Constitution Way
Litchfield, CT 06759

Dear Ms. Vaughn,

Unannounced visits were made to Brandywine Living At Litchfield on September 17 and 20, 2021 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing inspection renewal and conplaint investigation.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits. The state violations cannot be edited by the provider in any way.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by October 29, 2021.

The plan of correction shall include:
(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;
(2) the date each such corrective measure or change by the institution is effective;
(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and
(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the

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THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by October 29, 2021 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please return your response to Cheryl Davis, PHSM, at cheryl.davis@ct.gov. Please direct your questions concerning the instructions contained in this letter to Cheryl directly at (860) 509-7436. Please do not send another copy via US mail.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

/s/

Cheryl Davis RN, BSN
Public Health Services Manager
Facility Licensing and Investigations Section (FLIS)

CD:csf

c. VL
Complaint # 30454

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (d) Governing authority of an assisted living services agency (4) (A) and/or (g) Supervisor of Assisted Living (2) (A) and/or (B) and/or (h) Nursing Services provided by an assisted living services agency (4) and/or (k) Client service record (2) (J).

1. Based on clinical record reviews, interviews with agency personnel, for five of five clients (Client #1, #2, #3, #4 & #5) who required the administration of narcotics, an Assisted Living Services Agency (ALSA) nurse failed to document narcotics in accordance with ALSA policies and procedures and the ALSA failed to provide oversight of the administration of narcotics to Clients by agency nurses. The findings included:
   a. Client #1 was admitted to the ALSA program on 12/28/18 with diagnoses that included Parkinson's Disease, osteoarthritis, asthma, and glaucoma. The Client's service plan dated 07/17/21, identified the Client required medication administration by ALSA nurses. The Client's medications included Tylenol with Codeine (300/30 milligrams) one tablet by mouth every six hours four times per day as needed for moderate pain.
   Interview and review of Client #1's Narcotic Administration Record and electronic Medication Administration Record (MAR) with the Registered Nurse (RN) Designee on 09/20/21 at 11:57 AM, identified day shift Licensed Practical Nurse (LPN) #1 documented the administration of Tylenol with Codeine to Client #1 at 2:08 PM on 07/14/21 in the electronic MAR but failed to document in the Client's Narcotic Administration Record. RN Designee received a call on 07/15/21 at 03:25 AM from LPN #2 who identified at 10:30 PM on 07/14/21 during change of shift narcotic count, Client #1's Tylenol with Codeine was off by two pills. RN Designee identified an investigation was started on the morning of 07/15/21.
   b. Interview and review of the ALSA's investigation, Client #1's Narcotic Administration Record and electronic MAR dated 07/01/21 through 07/15/21 with Supervisor of Assisted Living Services (SALSA) on 09/20/21 at 1:03 PM, identified the event on 07/14/21 triggered the SALSA to perform a retrospective review of Client #1,2,3,4 and 5's Narcotic Administration Records and electronic MARs from the periods of 09/20 through 07/2. The investigation concluded LPN #1 failed to document the administration of a subsequent dose of Tylenol with Codeine to Client #1 resulting in the incorrect narcotic count on 07/14/21. Additionally, LPN #1 failed to document the administration of narcotics in Client #1,2,3,4 and 5's electronic MAR. As a result of the investigation, the LPN was relieved of her duties at the ALSA. Although, the ALSA did not have a policy on routine RN oversite of Clients' Narcotic Administration Records, the SALSA indicated it was responsibility of the SALSA and/or RN Designee to oversee Clients' Narcotic Administration Records to prevent misuse and discrepancies.

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c. Client #2 was admitted to the ALSA program on 07/02/20 with diagnoses that included anxiety, spinal stenosis, and muscle weakness. The Client's service plan dated 06/27/21, identified Client #2 required medication administration by ALSA nurses. The Client's medications included Lorazepam 1mg one tab by mouth twice daily for anxiety.
Interview and review of Client #2's Narcotic Administration Record and electronic MAR dated 07/01/21 through 07/31/21 with Supervisor of Assisted Living Services (SALSA) on 09/20/21 at 1:10 PM, identified Client #2 received one 1mg Lorazepam tablet at 9:42 AM on 07/02/21 as indicated by LPN #3 in the Narcotic Administration Record and electronic MAR. Subsequently on 07/02/21, LPN #1 documented in the Narcotic Administration Record at 10:00 AM the Client was administered one 1mg Lorazepam tablet but failed to document the administration in the electronic MAR. The SALSA failed to identified documentation of an incident report after the medication error was discovered.

d. Client #3 was admitted to the ALSA program on 11/05/18 with diagnoses that included arthritis, sciatica, multiple fractures, and cognitive deficits. The Client's service plans dated 07/11/21, identified Client #3 required medication administration by ALSA nurses. The Client's medications included Tramadol 50 mg one tablet three times a day as needed for pain.
Interview and review of Client #3's Narcotic Administration Record and electronic MAR dated 09/25/20 through 07/15/21 with Supervisor of Assisted Living Services (SALSA) on 09/20/21 at 1:15 PM, identified LPN #1 documented the administration of Tramadol to Client #3 in the Narcotic Administration Record from 09/25/20 through 07/14/21 but failed to document the administration in the electronic MAR.

e. Client #4 was admitted to the ALSA program on 11/14/16 with diagnoses that included spinal stenosis, chronic back pain, and dementia. The Client's service plan dated 07/11/21, identified Client #4 required medication administration by ALSA nurses. The Client's medications included Tramadol with Tylenol 37.5-325 mg one tablet at 4:00 PM, may request one dose at bedtime as needed for pain.
Interview and review of Client #4's Narcotic Administration Record and electronic MAR dated 04/05/21 through 07/15/21 with Supervisor of Assisted Living Services (SALSA) on 09/20/21 at 1:18 PM, identified LPN #1 documented the administration of Tramadol with Tylenol to Client #4 in the Narcotic Administration Record on the dates of 05/31/21, 06/11/21 and 06/13/21 but failed to document the administration in the electronic MAR.

f. Client #5 was admitted to the ALSA program on 11/30/18 with diagnoses that included arthritis, heart disease and kidney disease. The Client's service plan dated 07/17/21, identified Client #5 required medication administration by ALSA nurses. The Client's medications included Alprazolam 0.25 mg one tablet every eight hours as needed for anxiety and Tramadol 50 mg once every eight hours as needed for severe pain.
Interview and review of Client #5's Narcotic Administration Record and electronic MAR dated 03/26/21 through 07/15/21 with Supervisor of Assisted Living Services (SALSA) on 09/20/21 at 1:20 PM, identified LPN #1 documented the administration of Alprazolam to

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Client #5 in the Narcotic Administration Record on the dates of 04/01/21, 04/03/21, 04/05/21, 04/06/21, 04/08/21, 04/11/21, 04/12/21, 04/14/21, 04/15/21, 04/16/21, 04/21/21, 04/22/21, 04/28/21, 04/30/21, 05/04/21, 05/05/21, 06/28/21, 07/08/21, 07/09/21 and 07/12/21 and documented the administration of Tramadol to Client #5 in the Narcotic Administration Record on the dates of 05/05/21, 06/22/21, 06/26/21, 06/28/21, 07/02/21 and 07/05/21 but failed to document the administration in the electronic MAR.

g. Interview with Drug Enforcement Agency (DEA) Agent #1 on 10/14/21 at 11:30 AM, identified Agent #1 conducted a subsequent investigation on 09/22/21. The investigation concluded, LPN #1 did not divert narcotics from the ALSA but failed to document narcotic administration in accordance with the ALSA's Controlled Substances Inventory and Tracking policy.

Review of the ALSA policy on Controlled Substances and Medication Error Reporting, identified separate records (the Client's individual narcotic administration record) would be maintained on all controlled substances in the form of a declining inventory. Such a record would be accurately maintained. All controlled substances would be counted by the oncoming nurse and the outgoing nurse at the change of each shift. The nurses finding an incorrect count would notify the nursing supervisor and document the incorrect dose. Furthermore, the ALSA would take a proactive approach for prevention of medication errors by focusing on quality improvement activities involving medication administration such as monthly reviews of medication administration practices.

Plan of Correction for DPH Visit 9/17/21 & 9/20/21

PROBLEM #	CHANGES IMPLEMENTING	EFFECTIVE DATE	PLAN TO MONITOR CHANGE	TITLE RESPONSIBLE PERSON
1. A, B, C, D, E, F	Monthly audits of random narcotic administration records for accuracy of charting.	07/20/2021	Monthly, 25% of residents on narcotics will have records audited to ensure administration record matches ECP (MAR) charting. Any discrepancies will be addressed immediately and incident report generated. (ongoing process)	SALSA
	Institute new forms for narcotic administration and count to ensure accuracy and accountability.	07/20/2021	Separate documents for narcotic administration and narcotic count will be institued immediately and staff inserviced. (instituted/inserviced 7/20/21)	SALSA
	Monthly audits of random narcotic administration records for accuracy of count.	07/20/2021	Monthly, 25% of residents on narcotics will have records audited to ensure administration record matches count record. Any discrepancies will be addressed immediately and incident report generated. (ongoing process)	SALSA
	Reinforcement of narcotic count being performed by ongoing and offgoing nurse and procedure if discrepancy is found.	07/20/2021	Nurses are to perform count when coming on and going off shift. Staff inserviced that any discrepancies in count will be investigated immediately by ongoing/offgoing nurse and resolved. If resolution is not achieved, the ongoing/offgoing nurses will remain in the building and the on-call RN will be notified immediately.	SALSA

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